



REGISTRO DEL PACIENTE

(Para uso de la clinica solamente)

Date _____ Account # _____ Chart # _____

QUIEN ES EL/LA PACIENTE? Por favor escriba

Apellido del Paciente _____ Primer Nombre _____ Inicial _____
Direccion _____ Ciudad/Estado _____ Zip _____
Telefono de Casa (_____) _____ Telefono del Trabajo (_____) _____
Seguro Social del Paciente: _____ Fecha de Nacimiento del Paciente _____
Raza: Hispano Otro _____
Estado civil del Paciente: Soltero Casado Divorciado Viudo Otro _____
Sexo: Masculino Femenino
IMPORTANTE: Alguien en la lista anterior ha venido a esta clinica antes? NO SI _____

EN CAUSO DE EMERGENCIA

Nombre _____ Relacion con el Paciente _____
El numero de telephone do emergencia debe ser DIDERENTE de los de arriba: (_____) _____

PERSONA RESPONSABLE

Nombre de la Persona Responsable _____ Relacion con el apciente _____
Fecha de Nacimiento _____ Seguro Social de Persona Responsable # _____
Lugar de Empleo _____ Telefono del Trabajo (_____) _____
Direccion de Trabajo _____ Ciudad/Estrado/Zip _____

INFORMACION DE SEGUROS

Numero de MEDICAID _____ Numero de MEDICARE _____
Nombre de Asegurado _____ Fecha de Nacimiento del Asegurado _____
Numero de Telefono del Asegurado (_____) _____
Compania de Seguros _____ ID # _____ Grupo # _____
Fecha Efectivo _____ Fecha de Expiracion _____ Suma Deducible: \$ _____
Si tiene HOM Indequ Doctor/Grupo asignado _____
Trabajo de la persona asegurada _____ Direccion de Trabajo _____
Relacion con el paciente: MISMO ESPOSO/A HIJO/A OTHO _____



Consent for Treatment on Behalf of a Minor*

Name of minor patient: _____ Date of Birth ____/____/____

* A minor is an individual who is under 18 years of age who is not and has not been married or had the disabilities of minority removed by the court.

I am authorized to consent on behalf of the above minor as I am the minor's

parent or _____
State relationship to minor that grants authority

I _____ hereby and voluntarily consent to authorize the
Print the name of parent or legally authorized person

physicians, mid-level providers (Physician Assistant, Advance Practice Nurse) and dentists, if available, on MLK, Jr. Family Clinic staff at their service locations to provide health care services to the above minor. The health care services may include routine physical and mental assessment, diagnostic and monitoring tests and procedures, examinations and medical and/or dental treatment, if available. The health care services may include, but are not limited to, routine laboratory work, such as blood, urine and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the medical and/or dental staff. The health care services also may include counseling services necessary to receive appropriate services. I understand that family planning services for minors funded by Title V and Title XX require a separate parental consent form.

I have received the Patient and Center Rights and Responsibilities and the Notice of Patients Privacy Rights and understand those documents. I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and the minor's rights concerning these issues. I understand that this consent is valid and remains in effect as long as the minor is a patient of MLK, Jr. Family Clinic. I have been given an opportunity to ask questions about the services to be provided by this Center and I believe that I have sufficient information to give this consent.

I hereby delegate authority to consent to treatment for the above minor to
*(Print name) _____ for the period of ____/____/____ through ____/____/____.

*The individual delegated to give authority and receive authority for consent of treatment to minors must be 18 years of age or older.

Signature of Parent or Legal guardian

Witness

Print Name

Print Name

Date Time

Date Time

*Translated into _____ /Read to person consenting by:

Signature

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Print Name

Management and Operations Manual

Date Time

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